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No. 96 291 AUG 2 1 1996

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IN THE

Supreme Court of the United States

October Term, 1996

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Petitioner,

against

JAMES SQUARE NURSING HOME, INC.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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Dated: August 15, 1996

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Question Presented

Whether, in instances where health care providers are serving persons dually-eligible for Medicaid and Medicare and have agreed to accept Medicaid reimbursement as payment in full for services rendered under Medicaid, the State of New York, without violating the Medicaid and Medicare Acts, can recoup Medicare payments that the providers receive for those same services.

Parties

The parties to the proceeding are:

1. James Square Nursing Home, Inc., Plaintiff.

2. Brian Wing, as Acting Commissioner of the Department of Social Services, Defendant.

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No.

IN THE

Supreme Court of the United States

October Term, 1996

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Petitioner,

against

JAMES SQUARE NURSING HOME, INC.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

The petitioner, Brian Wing, as Acting Commissioner of the Department of Social Services of the State of New York, respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit entered in this action on May 23, 1996. The Second Circuit's judgment is annexed as Appendix "A". The judgment of the Second Circuit affirmed the final judgment of the United States District Court for the Northern District of New York, dated and filed September 6, 1995, which ruled that the State of New York's policy requiring that providers of health care services who receive Medicaid payments accept them as payment in full and that the Department of Social Services

recoup all third party resources including Medicare Part B receipts violates the provisions of the Medicare Act. The judgment of the District Court is annexed as Appendix "B".

Opinions Below

The opinion of the Second Circuit, rendered on May 23, 1996, is officially reported at 84 F3d 591. It is appended as Appendix "C".

The opinion of the District Court, rendered on August 29, 1995, is reported at 897 F Supp 682. That "Decision and Order" is appended as Appendix "D".

Jurisdiction

The judgment of the Second Circuit was entered May 23, 1996. This petition for certiorari is filed within 90 days of May 23, 1996. The Court's jurisdiction to review the case rests upon 28 USC § 1254(1).

Statutory Provisions Involved

This case involves the construction and application of various provisions of the Medicare Act (42 USC § 1395, *et seq.*) and the Medicaid Act (42 USC § 1396, *et seq.*). Pertinent parts of these statutes are set forth in the Appendix.

Statement of the Case

The Medicaid Act, 42 USC § 1396, *et seq.*, establishes a program for subsidizing medical care for the needy. The federal government and states that choose to participate in the program, as does New York, jointly fund the Medicaid program. 42 USC

§ 1396d(b). The funds provided under the Medicaid Act are available to participating states that have submitted plans approved by the Secretary of Health and Human Services. 42 USC §§ 1396a(a), 1396a(b). The state's plan must include, among other things, a schedule of payment rates which the state designates for various kinds of care that a Medicaid patient might seek. 42 USC § 1396a(a)(13). Under 42 USC § 1396a (a)(13)(A), Medicaid rates must be "reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities". In New York, approximately fifty percent of the costs of the Medicaid program are paid by the federal government; the other fifty percent are paid by the state and local governments.

The New York State Department of Health establishes Medicaid reimbursement rates for each residential health care facility in accordance with Article 28 of the Public Health Law and 10 NYCRR Part 86-2. For nursing homes, reimbursement for services is made by means of an average per diem, per patient rate. For every day a Medicaid recipient is in residence at the facility, the facility bills the Medicaid program at a per diem rate previously established specifically for that facility. This average per diem, per patient rate is used regardless of the nature and scope of services provided to a particular patient on any given day. The costs covered by the Medicaid rates include both the direct costs of providing care to patients including physicians' and ancillary services plus indirect costs for administration, capital amortization, utility bills and depreciation of equipment. *See,* 10 NYCRR 86-2.10(b)(1)(ii). New York's current rate-setting methodology is prospective in nature. The New York State Department of Social Services administers the Medicaid program pursuant to the rates established by the Department of Health (NY Social Services Law §§ 20, 34, 363-a, 364 and 365) and has the responsibility for auditing providers

to identify any overpayments. 18 NYCRR Parts 504, 515, 517 and 518.

The Medicare Act, 42 USC § 1395, *et seq.*, establishes a federally funded program for subsidizing medical care to the elderly and disabled. Medicare coverage consists of two parts. Part A, which is not involved here, covers in-patient hospital expenses through an insurance plan. *See,* 42 USC §§ 1395c to 1395i-4. Part B covers physicians' services and other ancillary services not covered by Part A, such as physical therapy, occupational therapy, speech therapy, oxygen services, laboratory services and medical supplies for residents of health care facilities who are eligible. *See,* 42 USC §§ 1395j to 1395w-4(j). To obtain Part B coverage, patients must enroll by paying insurance premiums. *See,* 42 USC §§ 1395o-1395s. The federal government then pays 80 percent of the "reasonable" charges for the covered physician fees and charges for ancillary services, while the Part B patients themselves are responsible for a 20 percent copayment as well as an annual deductible. *See,* 42 USC §§ 13951, 1395cc(a)(2)(A). Reasonable costs and charges for the services covered under Part B are established by the Secretary of Health and Human Services pursuant to the Medicare Act and its implementing regulations. *See,* 42 USC § 1395w-4(a), (b). The service provider bills the federal government directly and is reimbursed on a fee-for-service basis.

When elderly or disabled persons eligible under the Medicare Act also meet financial eligibility criteria under the Medicaid Act, they are known as "dual eligibles". Pursuant to a buy-in agreement between New York and the federal government, the State enrolls its Medicaid recipients who are also eligible for Medicare in Part B by paying annual premiums for such individuals, and in addition pays the copayments and annual deductibles. *See,* 42 USC § 1395v. Residential health care

facilities often receive double payment for the services they provide to dual eligibles—once as part of the per diem rates set prospectively by the State of New York under the Medicaid program and again on a fee-for-service basis from the federal government under the Medicare program. In order to avoid this windfall, the State Department of Social Services seeks, upon audit, to recoup from nursing homes any Medicare Part B receipts for services covered by the Medicaid rates established by the State Department of Health.[1]

Plaintiff James Square Nursing Home operates a 455-bed residential health care facility which is licensed by the Commissioner of Health pursuant to Article 28 of the New York Public Health Law and is a participating provider in the Medicaid and Medicare programs (JA 10, 32). [2] The Department of Social Services audited the funds that plaintiff received from Medicare Part B for its dual eligibles for the rate years 1986 and 1987. On January 10, 1991, the State issued a final audit report in which it concluded that plaintiff had received double payment for the provision of ancillary services in the amount of $246,286 (JA 16, 35).

On April 12, 1993, plaintiff commenced this action in the Northern District of New York pursuant to 42 USC § 1983 (JA 7-23). The complaint seeks declaratory and injunctive relief preventing defendant from using the current audit methodology

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[1]The State Department of Health when establishing Medicaid rates carves out a portion of those rates for dual eligibles to represent the facility's historical Medicare Part B receipts. Upon audit, the "carve-out" is adjusted to reflect actual Part B receipts.

[2]References appearing as ("JA__") refer to the Joint Appendix filed in the Second Circuit.

for recouping its Medicare receipts to the extent that they exceed Medicaid rates (JA 22-23). Plaintiff claims that defendant's methodology deprives it of its right to be compensated reasonably in violation of the Medicare Act and results in an assignment of Medicare benefits in violation of federal regulations (JA 19-22). Plaintiff also moved for a preliminary injunction to prevent defendants from recouping funds as a result of the Medicare Part B audits for 1986 and 1987 (Record on Appeal, Docket Entry No. 2, Order to Show Cause).[3]

After defendant duly answered (JA 24-27), both parties moved for summary judgment (JA 28-29, 62-63). In its decision filed August 29, 1995, the district court (Scullin, J.) held that while the defendant is entitled to offset its Medicaid rate to prevent double payment for physician and ancillary services, DSS' methodology for doing so, as applied in this case, violates the Medicare and Medicaid Acts because it prevented plaintiff from receiving payment for the full reasonable costs and charges of the services provided to Medicare patients (App D, 897 F Supp 682). The district court relied heavily on *New York City Health and Hosps. Corp. v. Perales*, 954 F2d 854 (2d Cir), *cert denied*, 506 US 972 (1992), which it read as holding across the board that dual eligible patients must be considered primarily Medicare patients for whom services must be reimbursed at full Medicare rates (App 15a-18a, 897 F Supp at 685-686). The district court rejected defendant's contentions that this case is distinguishable on the ground that the provider has already accepted Medicaid payment as payment in full and that, because

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[3]Initially by court order, and later by consent of the parties, a temporary restraining order was issued preventing defendants from recouping any funds from plaintiff as a result of Medicare Part B audits for the years 1986 through 1991 pending a decision on the preliminary injunction motion (Record on Appeal, Docket Entry Nos. 9, 21, 32).

Medicaid and Medicare rates are determined in fundamentally different ways, it is not possible to ascertain what portion of the Medicaid per diem rate is attributable to the cost of services covered by Medicare Part B (App 18a-19a, 897 F Supp at 687). The court, therefore, granted plaintiff's motion for summary judgment (App 20a, 897 F Supp at 687-688).

The Court of Appeals for the Second Circuit, in a per curiam opinion rendered May 23, 1996, affirmed the judgment of the district court "substantially for the reasons set forth in its decision and order" (App 7a, 84 F3d at 591).

REASONS FOR GRANTING THE WRIT

POINT I

The decision below will have substantial fiscal and administrative ramifications for the State of New York.

The decision below will have substantial fiscal and administrative ramifications for the State of New York. The Department of Social Services estimates that, with regard to nursing homes, $20 million is at stake in pending audits, and $2 million will be lost annually. In addition, the decision below will apparently affect the Department's similar recoupment policy with regard to (1) hospitals which are reimbursed once Medicare Part A benefits are exhausted by Medicaid on a per case or per diem basis and again by Medicare Part B on a fee-for-service basis, resulting in a loss of recouped revenues of $20-50 million annually; and (2) home health care providers which receive a Medicaid hourly or per visit rate as well as Medicare Part B payments, resulting in an additional loss of recouped revenues of approximately $20-40 million annually. As with nursing homes, hospitals and home health care providers agree by statute

and contract to accept Medicaid reimbursement as payment in full for services rendered, and the State recoups any Medicare Part B receipts. The fiscal impacts described above include direct losses to the State of New York as well as the portions of the recouped revenues that the State would return to the federal and local governments in proportion to their respective funding responsibilities under the Medicaid program. *See,* 42 USC §§ 1396d(b), 1396k(b).

In addition to the fiscal impact of the decision, because of the structural differences between the Medicaid and Medicare Part B rate methodologies, i.e., the former being on an average per patient, per diem basis (or an hourly, per case, or per visit basis in the hospital and home health care contexts), and the latter being on a fee-for-service basis, significant administrative difficulties will be encountered in complying with the Second Circuit's decision. This apples-to-oranges comparison can result only in a rough estimate of payments received over and above the Medicare rate.

POINT II

The decision of the Court below conflicts with State appellate court decisions.

The decision below conflicts with decisions of the appellate courts of the State of New York, thereby creating a dilemma for the Department of Social Services as to its future course of action. In *Matter of Harr-Wood Nursing Home v Perales,* 113 AD2d 535 (3d Dept 1986), the Appellate Division, Third Department, addressed the identical issue plaintiff raises here and held that the State was entitled to recoup from a nursing facility an amount equivalent to what the facility had received from Medicare Part B for ancillary services. There, as here,

petitioner was a skilled nursing facility that provided ancillary services to its patients who were dual eligibles. The facility's per diem rate under the Medicaid program included reimbursement for such ancillary services. After an audit revealed that the facility had received Medicare Part B reimbursement for the same services, the Department of Social Services sought to recoup for the Medicaid program an amount equal to the facility's Medicare Part B receipts. The facility did not dispute that it had been paid twice but claimed that any recoupment should be limited to amounts received over and above the Medicare Part B rates.

The Appellate Division, Third Department, rejected petitioner's argument, concluding that the Department's methodology "squares with * * * the statutory identification of Medicaid as payor of last resort (42 U.S.C. §1396[1]; see also, 42 U.S.C. § 1396d[a]; Social Services Law § 366[2]; [former] 18 NYCRR 360.9, 360.22)." 113 AD2d at 538. The court also reasoned that it is not possible to compare Medicaid and Medicare rates on an equivalent basis, writing (113 AD2d at 538):

> "[P]etitioner's overall daily Medicaid rate is a single amount which covers, without distinction, the various services petitioner agreed to make available to its Medicaid recipients; that amount is based on a rate-making formula which takes into account both the direct and indirect costs of services, including, for instance, costs of utilities, maintenance, administration and capital (see, 10 NYCRR 86-2.10, 86-2.21). Apportionment of indirect costs attributable to ancillary services was rightly considered infeasible by respondent, for any such allocation would be arbitrary or premised on artificial distinctions."

The Appellate Division, Fourth Department, in *Matter of Aurora Park Health Care Center v. Bane,* 209 AD2d 974 (4th Dept 1994), recently reaffirmed the *Harr-Wood* ruling in dicta, rejecting the nursing facility's argument that the Second Circuit's decision in *New York City Health and Hosps. Corp. v Perales,* 954 F2d 854, effectively overruled that decision by holding that dual eligibles must primarily be considered Medicare, not Medicaid, patients. In *Aurora Park,* the New York Supreme Court, Erie County, had held *New York City Health and Hosps. Corp. v. Perales* to be dispositive. The Appellate Division reversed first on the ground that petitioner had failed to exhaust its administrative remedies with regard to that argument. The Fourth Department continued, however: "[w]ere we to reach the merits, we would agree with the determination of the Administrative Law Judge [holding that DSS could recoup an amount equal to all of the reimbursement for Part B services]." 209 AD2d at 974.

POINT III

The decision below is erroneous.

"Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *New York State Department of Social Services v Bowen,* 846 F2d 129, 133 (2d Cir 1988), quoting S Rep No. 146, 99th Cong, 2d Sess 1, 312 (reprinted in 1986 US Code Cong & Admin News 42, 279). Pursuant to 42 USC § 1396a(a)(25), all State Medicaid programs must pursue third party resources (including health insurers) and reduce Medicaid reimbursement by the amount of reimbursement available from the third parties. A State must "take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and services

available under the [State's] plan," 42 USC § 1396a(a)(25)(A), and whenever such "legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the cost of such recovery, the State * * * will seek reimbursement for such assistance to the extent of such legal liability," 42 USC § 1396a(a)(25)(B). The Medicaid statute further provides that every person seeking Medicaid assistance is required to assign to the State his or her rights to medical expenses from any "third parties" and to cooperate with the State in seeking recoupment of those expenses from them. 42 USC § 1396a(a)(25)(I), (45); § 1396k(a).

The Second Circuit, in *New York State Department of Social Services v Bowen*, 846 F2d 129 (2d Cir 1988), expressly recognized the right of the State Department of Social Services under these provisions to recover from the United States Department of Health and Human Services Medicare Part B funds to which the recipient is entitled. The court observed, "It cannot be disputed * * * that Medicare is a 'third party' for purposes of the third party liability provision, 42 USC § 1396a(a)(25)". 846 F2d at 133, citing the lower court's extensive discussion of this issue at 661 F Supp 1537, 1551-52. The court concluded, "It is illogical to suggest * * * that the statutory and regulatory scheme of Medicare abrogates the principle that 'Medicaid is the payer of last resort' and renders unenforceable the Medicaid statutes requiring states to recover from all responsible third parties (including the Medicare program)". 846 F2d at 134.

Pursuant to this federal statutory authority, section 367-a(2)(b) of the New York Social Services Law subrogates the Department of Social Services to "any rights [a Medicaid

recipient] may have to medical support or third party reimbursement". Section 366(4)(h) requires Medicaid recipients to assign their rights to benefits from third parties to the Department. *See also*, 18 NYCRR 540.6(e) and 540.7(a)(8).

In addition, under both federal and New York State law, Medicaid payment constitutes payment in full for medical services provided to a Medicaid recipient. *See*, 42 USC § 1320a-7b(d);[4] N.Y. Pub. Health Law § 2805-f(4). All states participating in the Medicaid program must comply with 42 CFR 447.15, which provides:

> "A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual."

Pursuant to 18 NYCRR 540.7(a)(8), whenever a provider bills the Medicaid program, it must acknowledge that "payment of fees and rates made in accordance with established schedules is accepted as payment in full for the care, services and supplies provided * * *".

Because Medicaid is the payor of last resort and its payment constitutes payment in full for the services billed, the Medicaid statute mandates that the State pursue Medicare Part B receipts just as it would pursue payments received for the same services

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[4]42 USC § 1320a-7b(d) makes it a felony for "[w]hoever knowingly and willfully * * * charges, for any service provided to a patient under a State [Medicaid] plan, * * * money or other consideration in excess of the rates established by the State."

from any other third-party sources. Thus, where the costs of physician and ancillary services were included in the calculation of the Medicaid rate as they were in this case, the Department of Social Services is entitled to recover Medicare Part B payments made to cover the same services. Because Medicaid reimbursement constitutes the legally exclusive payment for the services rendered, a participating provider may not retain payments from third parties even if its actual costs exceeded the Medicaid reimbursement. As stated in *Evanston Hosps. v Hauck,* 1 F3d 540, 542 (7th Cir 1993), *cert denied,* 510 US 1091 (1994), "[b]y opting for reimbursement from Medicaid, [the] [h]ospital bought certainty. It purchased a guarantee of partial payment in lieu of possibly full payment or possibly no payment at all."

The decision of the Second Circuit in *New York City Health and Hosps. Corp. v Perales,* 954 F2d 854, as well as those of its sister circuits holding that Medicare rates apply where a patient is eligible for both Medicare and Medicaid programs, are distinguishable. *See, Rehabilitation Assn. of Virginia, Inc. v Kozlowski,* 42 F3d 1444 (4th Cir 1994), *cert denied sub nom. Metcalf v Rehabilitation Assn. of Virginia, Inc.,* __US__, 116 S Ct 60, 133 L Ed 2d 23 (1995); *Haynes Ambulance Service, Inc. v Alabama,* 36 F3d 1074 (11th Cir 1994); *Pennsylvania Medical Society v Snider,* 29 F3d 886 (3d Cir 1994). None of these cases addressed the issue in the context where a provider of comprehensive nursing home services which has *already received* Medicaid payment for services under a per diem reimbursement scheme seeks to retain Medicare fee-for-service receipts for the same services. Rather, they involved payment for physicians' services and other individual hospital services for which the providers had not already accepted, on a contractual basis, Medicaid reimbursement as payment in full but were seeking Medicare reimbursement in the first instance. The states in those cases unilaterally imposed Medicaid cost ceilings on the co-

payments and deductibles under Medicare Part B that they were required to reimburse the providers of services for dual eligibles. In holding the State's actions improper, the court in *New York City Health and Hosps. Corp. v. Perales* rested its decision on the interpretation of two provisions of the Medicaid statute that specifically provided for the cost-sharing obligations of the states, i.e., 42 USC § 1396a(a)(10)(E) and 1396a(n), where only Medicare payments were being sought in the first instance.

Additionally, the concerns underlying the decision in *New York City Health and Hosps. Corp. v Perales,* i.e. that "Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled", 954 F2d at 859 are not present in this situation, since the nursing home providers have already agreed to accept an average per patient, per diem rate for all of its patients under the Medicaid program. The courts below wrongly expanded the holding to reach their conclusion here that Medicare is not a third party liable for the care and services paid by Medicaid, a conclusion that is directly contrary to the court's ruling in *Bowen* that "it cannot be disputed * * * that Medicare is a 'third party' for purposes of the third party liability provision, 42 USC § 1396a(a)(25)". 846 F2d at 133.

Furthermore, the issue decided in *New York City Health and Hosps. Corp. v Perales* and these other cases continues to be litigated by the Secretary of Health and Human Resources and other states. *See, Beverly Community Hosp. Assn. v Belshe,* No. 95-4053 JSL, 64 USLW 2447 (CD Cal Dec. 18, 1995), appeal docketed No. 96-44208 (9th Cir Feb. 1, 1996); *California Ambulance Assn. v. Shalala,* No. CV 96-2322 (CD Cal July 25, 1996), appeal filed (9th Cir July 30, 1996); *Paramount Health Systems, Inc. v Wright,* No. 95-C-1620 (ND Ill July 29, 1996), decision stayed pending appeal. We do not concede that the

Second Circuit correctly decided *New York City Health and Hosps. Corp. v Perales.*

In summation, a health care facility that provides comprehensive services, when it accepts payment under the Medicaid program for costs for its nursing home services, accepts such payment by Medicaid as payment in full. The State is required by federal and State law to seek reimbursement from any third party liable for those services, including Medicare. The decisions of the various circuits construing the cost-sharing provisions of the Medicare Act, even if properly decided, do not require otherwise.

Conclusion

For the reasons stated, the Petition for a Writ of Certiorari should be granted.

Dated: Albany, New York
August 15, 1996

Respectfully submitted,

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APPENDIX A—Judgment of the Court of Appeals for the Second Circuit, dated May 23, 1996.

United States Court of Appeals
for the Second Circuit
United States Court House
40 Foley Square
New York 10007

George Lange III
Clerk

At a Stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 23rd day of May, one thousand nine hundred and ninety-six.

PRESENT: HON. Ellsworth A. Van Graafeiland
HON. J. Daniel Mahoney
Circuit Judges
HON. Robert L. Carter*
District Judge

Docket No: 95-9044

JAMES SQUARE NURSING HOME, INC.,

Plaintiff-Appellee,

v.

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Defendant-Appellant.

---

*The Honorable Robert L. Carter, of the United States District Court for the Southern District of New York, sitting by designation.

Appeal from United States District Court for the Northern District of New York.

This cause came on to be heard on the transcript of record from the Northern District of New York and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby **ORDERED, ADJUDGED, and DECREED** that the judgment of said district court be and it hereby is affirmed in accordance with the opinion of this court.

For the Court
GEORGE LANGE III, Clerk
By: s/Beth J. Meador
Beth J. Meador
Administrative Attorney

United States Court of Appeals
Second Circuit
Filed

May 23 1996

George Lange III, Clerk

APPENDIX B—Judgment of the District Court for the Northern District of New York, dated September 6, 1995.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

JUDGMENT IN A CIVIL CASE

JAMES SQUARE NURSING HOME, INC.,

v. CASE NUMBER 93-CV-477 (FJS)

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York

[X] Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

that the motion for the New York State Health Facilities Association, Inc., to appear as Amicus Curiae in this action is granted, further ordered that the defendant's motion for Summary Judgment is denied and the Cross-Motion by plaintiff is granted. The defendant is enjoined from applying their audit policy to plaintiff for the years of 1986 through 1991.

Further ordered that the defendant's audit policy as applied in this case violates the Medicare Act 42 USC 1395 et seq. and the Medicare Act 42 USC 1396 et seq.

All of the above pursuant to the order of the Honorable Frederick J. Scullin Jr., dated the 29th day of August, 1995.

September 6, 1995	GEORGE A. RAY
DATE	CLERK
	s/Joanne Walker (BY) DEPUTY CLERK

U.S. District Court
N.D. of N.Y.
Filed

Sep 6 1995

At O'Clock M
George A. Ray, Clerk
Syracuse

APPENDIX C—Opinion of the Court of Appeals for the Second Circuit, dated May 23, 1996

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1294 - August Term, 1995

(Argued: April 26, 1996 Decided: May 23, 1996)

Docket No. 95-9044

JAMES SQUARE NURSING HOME, INC.,

Plaintiff-Appellee,

- vs. -

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Defendant-Appellant.

Before: VAN GRAAFEILAND and MAHONEY, *Circuit Judges*, and CARTER,* *District Judge*.

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*The Honorable Robert L. Carter, of the United States District Court for the Southern District of New York, sitting by designation.

Appeal from a judgment entered in the United States District Court for the Northern District of New York that granted plaintiff-appellee's motion for summary judgment on its claim pursuant to 42 U.S.C. § 1983 for injunctive and declaratory relief under the Medicare Act, 42 U.S.C. § 1395 *et seq.*, and the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, with respect to New York's audit policy for recouping Medicare payments made to health providers who serve patients eligible under both the Medicare and Medicaid programs.

Affirmed.

CINDI R. BRANDT, New York, New York, (Jerome T. Levy, Kronish, Lieb, Weiner & Hellman, LLP, New York, New York, of counsel), *for Plaintiff-Appellee.*

DENISE A. HARTMAN, Assistant Attorney General for the State of New York, Albany, New York (Dennis C. Vacco, Attorney General, Peter H. Schiff, Deputy Solicitor General, Nancy A. Spiegel, Assistant Attorney General, Albany, New York, of counsel), *for Defendant-Appellant.*

PER CURIAM:

Defendant-appellant Brian Wing, acting Commissioner of the Department of Social Services of the State of New York ("New York"), appeals from a judgment entered September 6, 1995 in the United States District Court for the Northern District of New York, Frederick J. Scullin, Jr., *Judge*, that granted summary judgment to plaintiff-appellee James Square Nursing Home, Inc.

("James Square") on its claim pursuant to 42 U.S.C. § 1983 for injunctive and declaratory relief under the Medicare Act, 42 U.S.C. § 1395 *et seq.*, and the Medicaid Act, 42 U.S.C. § 1396 *et seq.* James Square's complaint alleges that New York's procedure for ensuring that James Square does not receive payment from both Medicare and Medicaid for medical services that James Square provides to persons eligible under both programs ("dual eligibles") violates the Medicare and Medicaid Acts. New York offsets against the Medicaid payments that it makes to James Square for services rendered to dual eligibles the full amount of Medicare Part B payments received by James Square with respect to those services. On this appeal, New York contends that its method of accounting for Medicare payments made for medical services also covered by Medicaid violates neither statute.

We affirm the judgment of the district court substantially for the reasons set forth in its decision and order. *See James Square Nursing Home, Inc. v. Wing*, 897 F. Supp. 682 (N.D.N.Y. 1995).

APPENDIX D—Opinion of the District Court for the Northern District of New York dated August 29, 1995

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

JAMES SQUARE NURSING HOME, INC.,

Plaintiff,

-against-

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Defendant.

CIVIL NO. 93-CV-477
(FJS)

Appearances:

Sherrin & Glasel, 74 North Pearl Street, Albany, New York 12207

Kronish, Lieb, Weiner & Hellman, 1345 Avenue of the Americas, New York, New York 10105

Of Counsel:

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Cornelius D. Murray

Attorneys for Amicus Curiae

Frederick J. Scullin, Jr., D.J.:

DECISION AND ORDER

Introduction

This matter is before the Court on plaintiff James Square Nursing Home, Inc.'s ("James Square") motion for a preliminary injunction and on the parties' cross-motions for summary judgment. James Square is a nursing home that provides services to Medicare and Medicaid patients. Defendant Brian

Wing is the Acting Commissioner of the Department of Social Services for the State of New York who is in charge of administering and implementing the Medicaid program in New York.[1] In the underlying 42 U.S.C. § 1983 action, plaintiff seeks declaratory and injunctive relief preventing defendant from utilizing its Medicaid audit procedure to secure reimbursement for alleged overpayment of Medicaid funds. Initially by order of the Court, and later by consent of the parties, a Temporary Restraining Order issued that enjoins defendant from recouping any funds from plaintiff as a result of its Medicaid audit for the years 1986 through 1991. Plaintiff then moved for a preliminary injunction, and thereafter, both parties moved for summary judgment. By consent of the parties the Court consolidated all the motions, which are the subject of this Decision and Order.[2]

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[1]Gregory Kaladjian was the Acting Commissioner of the Department of Social Services when this action was initiated. Since then, Brian Wing has been substituted as Acting Commissioner and, accordingly, is hereby substituted as the named defendant in this action. Fed.R.Civ.P. 25(d).

[2]Also before the Court is a motion by the New York State Health Facilities Association, Inc. ("NYSHFA") to appear as Amicus Curiae. The district court has broad inherent authority to permit or deny an appearance as amicus curiae in a case. *United States v. Ahmed*, 788 F. Supp. 196, 198 n.1. (S.D.N.Y.), *aff'd*, 980 F.2d 161 (2d Cir. 1992). The defendants oppose the motion claiming that the NYSHFA (a not-for-profit association that represents about 240 nursing homes throughout New York State) is interested in the outcome of the case and has merely repeated arguments made by plaintiffs. Although "[t]he partiality of a would-be amicus is a factor to consider ...' [t]here is no rule ... that amici must be totally disinterested.'" *Concerned Area Residents v. Southview Farm*, 834 F. Supp. 1410, 1413 (W.D.N.Y. 1993) (quoting *Hoptowic v. Ray*, 682 F.2d 1237, 1260 (9th Cir. 1982)). After reviewing the submissions in this matter the Court grants NYSHFA's motion to appear as

(continued...)

Background

This action concerns the interplay between two distinct but related health care programs -- Medicare and Medicaid. A brief overview of the programs is a helpful beginning.

The Medicare Act, 42 U.S.C. §§ 1395 *et seq*. was enacted to provide medical insurance for people over 65 years of age and for certain disabled people. Part A of Medicare provides for payment of in-patient services. Enrollment in Part A is automatic. Part B of Medicare provides the option of receiving supplementary insurance for medical services not covered under Part A, including out-patient services, physician's services, physical therapy, drugs, speech therapy, occupational therapy, psychotherapy, social work and laboratory services (collectively referred to as "ancillary services"). *Id.* §§ 1395j to 1395w-4(j). To enroll in Part B, eligible patients must pay insurance premiums and an annual deductible. *Id.* §§ 1395o to 1395s. Once enrolled, the federal government pays 80% of the reasonable costs and charges for ancillary services, and the patients themselves must pay the remaining 20%. 42 U.S.C. § 1395cc(a)(2)(A). The premium, deductible and the 20% co-payment are collectively referred to as "cost-sharing amounts." Medicare reimburses providers based on a fee-for-service basis, that is, generally it pays for the reasonable costs and charges of each service rendered.

The Medicaid Act, 42 U.S.C. §§ 1396 *et seq*., was enacted to pay for medical care for poor people, regardless of age. The federal government and the states jointly fund the Medicaid program. Together, the participating state and the federal government provide 100% of a patient's Medicaid costs (with

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[2](...continued)
Amicus Curiae because it believes that NYSHFA's brief will aid in the determination of the motions at issue.

50-50 participation). *Id.* § 1396d(b). Unlike the Medicare fee-for-service payments, the Medicaid program in New York provides a daily ("per diem") rate for each patient at a particular facility. Generally, the per diem rate is an estimate of the average cost that a facility will incur for each patient, including costs for ancillary services and non-ancillary services. The per diem rate takes into account the direct costs (e.g., labor) and indirect costs (e.g., utilities and rent) associated with providing care, and is based in part on the cost of providing care in previous years. A facility receives the per diem rate for each day a Medicaid patient is treated, regardless of the actual nature and scope of treatment provided.

The Medicare program was designed to provide medical care to eligible elderly and disabled without regard to income. Thus Medicare is available to people who are needy enough to also be eligible for Medicaid. The people who are eligible for both Medicare and Medicaid are referred to as "dual eligibles." Because dual eligibles may not be able to afford the Medicare cost-sharing amounts, a state may agree to pay the cost-sharing amounts on their behalf and thereby acquire Part B coverage for them. 42 U.S.C. § 1395v. Such agreements are referred to as "buy-in" arrangements. Buy-in arrangements save states money because once the dual eligibles are covered by Medicare, the Federal government pays 80% of the reasonable costs and charges for ancillary services rather than the across-the-board 50% share of the Medicaid per diem. New York State has a buy-in arrangement for dual eligibles.

This case concerns the problem that arises when a health care facility provides ancillary services to dual eligibles and thus potentially may be reimbursed under both Medicare and Medicaid. At issue is whether the procedure developed by the state to prevent a health care facility from receiving double payment for the same service is appropriate.

In order to avoid paying a facility for ancillary services that Medicare is going to pay for, the state developed a method of offsetting its Medicaid payments. The state starts with the facility's Medicaid per diem rate, which, as stated, includes reimbursement for ancillary services and non-ancillary services. Then the state estimates, based on past experience, what the facility is going to receive from the federal government as payment from Medicare Part B for providing ancillary services (i.e., 80% of the reasonable costs and charges). The state then pays the facility its Medicaid per diem rate minus the estimate of the Medicare Part B payments. That offset is referred to as a "carveout." After a facility receives its actual Medicare Part B payment, the state conducts an audit of the facility to reconcile the carveout. If the audit reveals that the actual Medicare Part B payments exceeded the estimate, and thus reveals that the state carved out too small an amount, then the facility owes the state. If the audit reveals that the actual Medicare Part B payments were less than the estimate, and thus that the carveout was too large, then the facility is entitled to a refund. In short, the procedure developed by the state to assure that a provider does not receive double payment for ancillary services is simply to deduct whatever payment the provider receives from Medicare Part B for ancillary services from the Medicaid per diem rate owed to the provider by the state.[3]

The plaintiff claims that the Medicare Part B payments for ancillary services (i.e., 80% of the reasonable costs and charges) invariably exceed the portion of Medicaid per diem payments

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[3]It is worthy to note here that there is no dispute in this case that the state is paying its cost-sharing amounts for dual-eligible patients, that is, the state is paying the premiums, deductibles and 20% of the reasonable costs and charges for dual-eligible patients. The focus here is on the state's procedure of offsetting the Medicaid per diem rate by the amount that Medicare Part B pays for ancillary services (i.e., 80% of the reasonable costs and charges).

that cover the same services. Thus when the state offsets from the Medicaid payments an amount equal to the Medicare Part B payments, it is offsetting too much. The state claims that it cannot calculate exactly the portion of Medicaid per diem rate that specifically covers ancillary services and therefore it is entitled to offset the entire amount that the plaintiff receives from Medicare Part B for those services.

In the case at bar, the state audited the plaintiff in 1986 and 1987 to reconcile the carveout for those years. On January 10, 1991, the state notified plaintiff that based on plaintiff's actual Medicare Part B receipts, the carveout for 1986 and 1987 was too small, and that plaintiff owed the state $246,286. The plaintiff challenged the audit at an administrative hearing. On December 31, 1992, the Administrative Law Judge determined that the auditing method was proper and that the state was entitled to offset the Medicaid payments by the full amount that Medicare Part B paid for the ancillary services. Thereafter plaintiff initiated this action in federal court claiming that the state's actions violate the Medicare Act and Medicaid Act and seeking declaratory and injunctive relief preventing defendant from utilizing its audit policy to recover the alleged Medicaid overpayment from plaintiff.

Discussion

Plaintiff acknowledges that the state can properly offset its Medicaid rate to prevent a double payment for ancillary services, but that the state, by offsetting the full Medicare payment for those services, is offsetting too much. The plaintiff maintains that as a provider of ancillary services to Medicare patients it is entitled to the full 80% of the reasonable costs and charges from Medicare. As stated, the state claims that it is entitled to recoup the full amount that plaintiff receives as Medicare Part B payments for dual-eligible patients. A crucial issue that the

Court must first decide is whether the patient is considered primarily Medicare or primarily Medicaid.

That issue was most directly addressed in *New York City Health and Hospitals Corp. v. Perales*, 954 F.2d 854 (2d Cir.), *cert. denied*, 113 S.Ct. 461 (1992). There, the Second Circuit had to determine the legality of a regulation that prevented health providers from receiving the full Medicare rate for ancillary services provided to dual eligible patients. New York had enacted a regulation that provided that the state would not pay cost-sharing amounts for dual eligibles if the Medicare payment exceeded the Medicaid rate for those services.[4] *Id.* at 856-57. "[B]ecause the scheduled Medicaid payments [were] almost invariably less than 80% of the corresponding reasonable costs or charges of a given type under Medicare" the provider "almost never collect[ed] more than 80% of their reasonable

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[4]New York State offered the following illustration of how the regulation worked:

Example: Medicaid Fee or Rate = $45.00

Medicare Approved	[80%] Medicare Paid	Balance Due
$80.00	$6[4].00	$0.00

A claim should not be submitted to Medicaid in this example.

* * *

Example: Medicaid Fee or Rate - $50.00

Medicare Approved	[80%] Medicare Paid	Balance Due
$60.00	$48.00	$2.00

A claim should be submitted to Medicaid for the amount of $2.00.

N.Y.C. Health and Hospitals v. Perales, 954 F.2d 854, 857 (2d Cir.), *cert denied*, 113 S.Ct. 461 (1992). Because the court invalidated the regulation, the proper result in the illustration is that the provider should recover $16.00 as cost-sharing from the state in the first example and $12.00 in the second example.

costs or charges." *Id.* at 857. The state argued that dual eligible patient should be treated as primarily Medicaid patients and providers should not be entitled to recover from the state any amount above the Medicaid rate for ancillary services.

The court rejected the state's argument reasoning that dual eligibles must be considered as primarily Medicare patients.[5] *Health and Hospitals Corp.*, 954 F.2d at 858-59. The court held that under the Medicare Act, "providers who furnish medical care to Medicare-eligible patients have the right to collect 100% of their reasonable costs and charges." *Id.* at 858. The court further found that the Medicaid Act, 42 U.S.C. § 1396a(a)(10)(E) requires that state funds be made available to pay cost-sharing amounts and that 42 U.S.C. § 1396a(n) "clarif[ies] that the Medicaid Act does not prohibit a provider from accepting more than the Medicaid Rate." Thus, "a Medicare provider need not be satisfied with inadequate payment, i.e., less than reasonable costs or charges, even when that provider is treating a Medicare patient who happens also to be poor." *Id.* at 860; *accord Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886, 896 (3d Cir. 1994); *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444, 1459 (4th Cir. 1994); *Haynes Ambulance Serv. Inc. v. Alabama*, 36 F.3d 1074, 1076 (11th Cir. 1994).

Although *Health and Hospitals Corp.* is somewhat distinguishable, its holding that dual eligible patients must be considered primarily Medicare patients and a provider is entitled

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[5]The court explained that "[i]f Medicaid were in fact the controlling program, then one would expect providers to be compensated at the Medicaid rate, instead of at 80% of the Medicare rate." *Health and Hospitals Corp.*, 954 F.2d at 858. Furthermore, "Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled and indeed wanted to integrate *all* of those who were Medicare eligible into the existing health care system." *Id.* at 859.

to receive the full Medicare rate, that is, 100% of its reasonable costs and charges, is even more compelling in the present case.[6] Starting with the premise that the Medicare Part B payment for a particular ancillary service (i.e., 80% of the reasonable costs and charges) will be higher than the Medicaid rate for the same service,[7] it can easily be seen that the state's audit policy will result in the plaintiff receiving less than the Medicare rate for treating Medicare patients. Indeed the state admits that the plaintiff does not receive the Medicare rate for a particular service, rather the state tries to ensure that "the provider receives the *full Medicaid rate*, but no more, for its dual eligibles." Def's Mem. of Law in Support of Summary Judgment at 16 (emphasis added). Under the circumstances of this case, the state is withholding from the plaintiff federal funds intended for the provider of services. In accord with *Health and Hospitals Corp.*, 954 F.2d 854, dual-eligible patients are primarily Medicare

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[6]*Health and Hospitals Corp.* dealt with the state's obligation to pay Medicare cost-sharing amounts. At issue here is whether the state can prevent the plaintiff from receiving the full 80% of its reasonable costs and charges from Medicare.

[7]Of course the state does not accept this premise outright. The state contends that the rates cannot be directly compared because they are created in fundamentally different ways. However, it is beyond dispute that at least in some instances the Medicare Part B payment for ancillary services (i.e., 80% of the reasonable costs and charges) will exceed the Medicaid reimbursement for the same ancillary service. *See Health and Hospitals Corp.*, 954 F.2d at 857 (With respect to out-patient ancillary services the court noted that "the scheduled Medicaid payments are almost invariably less than 80% of the corresponding reasonable cost and charges of a given type of care under Medicare.")

patients and the plaintiff is entitled to receive the full Medicare rate for providing ancillary services to those patients.[8]

Notwithstanding the clear authority for this conclusion, the state further argues that its position is consistent with the principle that Medicaid is a payor of last resort. However, preventing the state from offsetting the full Medicare Part B payment does not offend that principle. As a payor of last resort, the state Medicaid agencies are empowered to seek reimbursement from third parties who are liable for care and services paid for by Medicaid, such as ancillary services. 42 U.S.C. § 1396a(a)(25). As a matter of common sense, Medicaid agencies can only recover to the extent that the third party is liable for the services and to the extent that Medicaid actually paid for the services. 10 N.Y.C.R.R. § 86-2.17(m) (The Medicaid per diem

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[8]The state relies on *Harr-wood Nursing Home v. Perales*, 497 N.Y.S.2d 203 (3d Dep't 1986) for the proposition that providers must accept the Medicaid rate as payment in full for Medicaid services. *Harr-wood* held that the state was entitled to recover all the Medicare Part B payments a provider received because the Medicaid rate also included payment for those services. *Id.*; *see also Rego Park Nursing Home v. Perales*, 615 N.Y.S.2d 773 (3d Dept. 1994). *Harr-wood*'s holding, however, seems to be based in part on the conclusion that if the provider were allowed to retain any of the Medicare Part B payments, the provider "may be viewed as having violated Federal law by charging Medicare at a rate greater than the medicaid rate (*see*, 42 U.S.C. § 1396h[d][1])." *Harr-wood*, 497 N.Y.S.2d at 205 n.*. The vitality of this conclusion is questionable, however, after *Health and Hospitals Corp.*, which specifically recognized 42 U.S.C. § 1396a(n), "authorizes payment beyond the Medicaid amount." *Health and Hospitals Corp.*, 954 F.2d at 859; *see also Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886, 890 (3d Cir. 1994) ("Section 1396a(n) states that a state plan may provide a payment amount for Part B services exceeding the amount otherwise payable under a Medicaid plan."). In any event, this Court does not find *Harr-wood* to be controlling authority.

rate "shall be reduced by income earned for Medicare Part B eligible services to the extent that Medicaid has paid for those services."). Even with this limitation Medicaid ultimately will not have to pay for the services for which Medicare is liable. Thus limiting the state's offset to the amount it actually paid for services does not prevent Medicaid from being a payor of last resort.[9]

Finally, the state contends that because the Medicaid and Medicare rates are determined in fundamentally different ways, it cannot determine what amount of the Medicaid per diem rate is attributable to the cost of ancillary services and therefore it is appropriate to offset the full Medicare payment, even though the Medicare rate is usually higher than that allowed under Medicaid. *See Harr-wood*, 497 N.Y.S.2d 203. The weakness of the state's argument is exposed when taken to its logical extreme. For example, if the Medicare Part B reimbursement were so generous that it exceeded the total Medicaid reimbursement (i.e., the costs of ancillary services and non-ancillary services), use of the state's audit policy would result in the state paying nothing for all the services rendered, and, would result in the provider paying money to the state. Such a result is nonsensical, and the Court refuses to accept such an argument.

The Court is not satisfied that the state cannot properly determine what portion of the Medicaid per diem rate is allocated to ancillary services. The mere fact that it may be difficult to develop a formula which would more accurately reflect the percentage of per diem attributable to ancillary services does not absolve the state of its responsibility to do so. Because dual-eligibles are treated primarily as Medicare patients, and because providers are entitled to recover 100% of

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[9]Of course, if the state is concerned that its Medicaid reimbursement rate is too high it can make necessary adjustments through the rate-making process.

their reasonable costs and charges for treating Medicare patients, the state's offset must be limited to what Medicaid would actually pay for the ancillary services provided to the dual eligible patients. Therefore, the state's audit allowing an offset for the amount paid by Medicare for ancillary services violates the Medicare Act, 42 U.S.C. §§ 1395 *et seq*. and the Medicaid Act, 42 U.S.C. §§ 1396 *et seq*. Accordingly plaintiff is entitled to summary judgment and a declaration that the state's policy violates the Medicare Act, 42 U.S.C. §§ 1395 *et seq*. and the Medicaid Act, 42 U.S.C. §§ 1396 *et seq*. and is entitled to an injunction enjoining the state from utilizing its audit policy.[10]

Therefore, it is hereby

ORDERED that the New York State Health Facilities Association, Inc.'s motion to appear as Amicus Curiae in this action is GRANTED; and it is further

ORDERED that plaintiff's motion for summary judgment is GRANTED and defendants are ENJOINED from applying their audit policy to plaintiff for the years 1986 through 1991; and it is further

ORDERED that defendant's audit policy as applied in this case violates the Medicare Act, 42 U.S.C. §§ 1395 *et seq*. and the Medicaid Act, 42 U.S.C. §§ 1396 *et seq*.

IT IS SO ORDERED.

DATED: August 29, 1995
Syracuse, New York

s/
FREDERICK J. SCULLIN, JR.
U.S. DISTRICT JUDGE

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[10]Because of the Court's holding, it need not resolve the plaintiff's remaining arguments.

APPENDIX E—Mandate of the Court of Appeals for the Second Circuit, dated June 18, 1996

United States Court of Appeals
for the Second Circuit
United States Court House
40 Foley Square
New York 10007

GEORGE LANGE III
Clerk

At a Stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York, on the 23rd day of May, one thousand nine hundred and ninety-six.

PRESENT: HON. Ellsworth A. Van Graafeiland
HON. J. Daniel Mahoney
Circuit Judges
HON. Robert L. Carter*
District Judge

Docket No: 95-9044

JAMES SQUARE NURSING HOME, INC.,

Plaintiff-Appellee,

v.

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Defendant-Appellant.

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*The Honorable Robert L. Carter, of the United States District Court for the Southern District of New York, sitting by designation.

Appeal from United States District Court for the Northern District of New York.

This cause came on to be heard on the transcript of record from the Northern District of New York and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby **ORDERED, ADJUDGED, and DECREED** that the judgment of said district court be and it hereby is affirmed in accordance with the opinion of this court.

For the Court
GEORGE LANGE III, Clerk
By: s/Beth J. Meador
Beth J. Meador
Administrative Attorney

United States Court of Appeals
Second Circuit
Filed

May 23, 1996

George Lange III, Clerk
Issued as Mandate. Jun 18 1996
A True Copy
s/George Lange III, Clerk

APPENDIX F—42 USC § 1320a-7b(d)

42 USC § 1320a-7b. Criminal penalties for acts involving Medicare or State health care programs

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully --

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State, or

* * *

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

APPENDIX G—42 USC § 1396a(a)(25),(45)

42 USC § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must --

* * *

(25) provide --

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)]), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including --

(i) the collection of sufficient information (including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b-14 of this title and any additional information as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall --

(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1396b(r) of this title, and

(II) be subject to the provisions of section 1396b(r)(4) of this title relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any

other monitoring, quality control, or auditing requirements;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

* * *

(I) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

* * *

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

APPENDIX H—42 USC § 1396k

42 USC § 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall--

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required --

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

* * *

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

* * *

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.